(C) The date the asset was acquired,
(D) The cost of the asset,
(E) The salvage value of the asset,
(F) The depreciation cost,
(G) The estimated useful life of the asset,
(H) The depreciation expense each year,
(I) The accumulated depreciation.

(6) The recovery of losses associated with the disposal or abandonment of assets used to provide necessary services to the Medicaid program shall be determined on a case-by-case basis. Requests for recovery shall be made in writing and are subject to prior Division of Medical Assistance approval. Failure to acquire approval shall result in the disallowance of said costs, unless failure to acquire approval was caused by reasons beyond the control of the provider.

(7) The treatment of gains associated with the disposal of assets used to provide necessary services to the Medicaid program shall be based on this plan and the Medicare Principles of Reimbursement as contained in the HCFA-15.

(k) Interest cost may be considered an allowable cost subject to the following conditions, and the limits included in paragraph (k)(l) of this section:

(1) Interest for capital indebtedness, where the interest expense results from the initial financing of the capital indebtedness and the capital indebtedness represents all or part of the current Division of Medical Assistance approved value of the property. The property shall be necessary for the provision of adequate service, as determined by the Department of Human Resources, to the clients of the ICF-MR facility. The financing shall be prudently incurred, based on the HCFA-15, generally accepted accounting principles, and the preponderance of evidence derived from an in-depth case by case review of all related facts and circumstances.

(2) The interest rate shall not be in excess of the amount a prudent borrower would pay at the time the loan was incurred. In determining the reasonableness of the interest rate, all associated factors at the time the loan was incurred shall be considered, including, but not limited to the following:
(A) Current market rates of interest in the economy.
(B) Industry specific rates of interest.
(C) Provider specific financial position.

(3) The loan agreement shall be entered into between parties not related through control, ownership, affiliation, or personal relationship as defined in the Medicare Principles of Reimbursement as reflected in the HCFA-15, unless this provision is waived in writing by the Division of Medical Assistance. Such waiver shall be based on, but not limited to, a demonstration of need for the indebtedness and cost savings resulting from the transaction. The burden of proof shall be on the provider to provide proper support and justification for such waiver to the Division of Medical Assistance. Loans from a related party must be clearly identified and reported separately on the annual cost report.

(4) Interest expense on working capital indebtedness is allowable, subject to the Division of Medical Assistance's approved level of working capital, based on the HCFA-15, generally accepted accounting principles, and the preponderance of evidence derived from an in-depth case by case review of all related facts and circumstances.

(A) Interest on excess working capital is specifically denied.

(B) Working capital shall be established at the level necessary to support the facility's operations, after taking into full consideration the lead/lag impact of the facility's expenditures and reimbursements.

(5) Interest expense for capital indebtedness where the interest expense results from the refinancing of the capital indebtedness, and the refinancing has the prior approval of the Division of Medical Assistance, shall be allowed in that amount associated with the outstanding principal prior to refinancing. Interest costs may be allowed in excess of the amount associated with the outstanding principal balance prior to refinancing, if the purpose of the debt is to acquire assets to be used for care of persons served by the facility and all other applicable requirements of this plan are met. Interest expense resulting from the inclusion of the closing costs, such as, but not limited to, attorney's fees, recording costs and points in the refinancing transaction shall be considered allowable.

(A) The provider should file all necessary documents supporting its request for refinancing prior approval to the Division of Medical Assistance no later than 120 days prior to the proposed refinancing date.

(B) The Division of Medical Assistance shall render a decision regarding the prior approval request no later than thirty (30) days prior to the proposed refinancing date.

(C) Based upon just cause shown, the Division of Medical Assistance may waive the time requirements included in parts (k)(5)(A) and (B) of this Section, but in all cases there shall be enough time allowed to evaluate the proposed refinancing.

(6) In all cases, in order for the interest expense to be allowable it shall be necessary to satisfy a financial need related to the adequate provision of recipient care, as determined by the Division of Medical Assistance. Loans which result in excess funds or investments are not considered necessary.

(7) Interest expense shall not be allowable when related to loans that failed to receive prior approval, as required, from the Division of Medical Assistance, unless failure to acquire prior approval was caused by reasons beyond the control of the provider.

(8) In no event shall interest expense be allowed on a facility's cost that is deemed to be excessive.

(l) The annual capital cost or lease expense limitations shall apply:

(1) To all facilities with twenty-one (21) or more beds and to facilities consisting of multiple detached buildings in which at least one contains nine (9) certified beds. The facilities covered by this limit shall have been awarded a Certificate of Need before January 1, 1993. The annual capital cost or lease expense limit shall be the lesser of actual cost or

the sum of (A) and (B) as follows:

(A) The annual depreciation on plant and fixed equipment that would be computed on assets equal to thirty thousand dollars ($30,000) per bed (capital recovery base) during fiscal year 1982-83 adjusted for changes in the following cost indexes:

(i) For the period after 1982-83 and through the period 1991-92 the capital recovery base shall be adjusted for changes in the Dodge Building Cost Index of North Carolina Cities.

(ii) For the period beginning July 1, 1992 the capital recovery base shall be adjusted for changes in the implicit price deflator for residential structures as provided by the Office of State Budget and Management. Depreciation expense shall be computed using the straight line method of depreciation and the useful life standards established by the American Hospital Association.

(B) An interest allowance equal to ten percent (10%) of the capital recovery base used to compute annual depreciation on plant and fixed equipment.

(C) This annual capital cost or lease expense limit does not apply to leases in effect prior to August 3, 1983.

(2) To all facilities that have been awarded a Certificate of Need on or after January 1, 1993, the annual capital cost or lease expense shall be limited to the lesser of actual cost or the fair and reasonable depreciation and interest at the time of certification and enrollment into the Medicaid program.

(A) Depreciation expense shall be computed using the straight line method of depreciation and the useful life standards established by the American Hospital Association.

(B) Interest expense is computed using a ten percent (10%) rate of interest.

(C) The capital recovery base is established as thirty thousand dollars ($30,000) of plant and fixed equipment assets per bed during the fiscal year 1982-83 adjusted for the changes in the cost indexes contained in subparagraphs (1)(1)(A), (i) and (ii) of this Section.

(D) Recovery of the cost of material additions to plant and fixed equipment subsequent to certification and enrollment in the Medicaid program shall be subject to review on a case by case basis, consistent with the provisions of this State Plan.

(E) This capital cost or lease expense limitation should be considered the absolute maximum allowable for Medicaid reimbursement. In evaluating the reasonableness of a particular facility's capital cost or lease expense, regional costs of land and construction should be considered. In cases where the reasonable regional costs are less than those derived from subparagraph (1)(2)(C) of this Section, above, then the regional costs should be used in determining the appropriate capital cost or lease expense limitations.

(i) In determining fair and reasonable facility cost, the average cost of similar construction in the same local area should be used. This test of reasonableness should be applied to all components of the facility's construction cost, including square footage and per unit costs.

(ii) Absent strong, clear justification to the contrary, no six (6) bed facility shall be allowed to recover capital cost and lease expense related to square footage in excess of 3200 square feet.

(3) Failure to provide supporting evidence of actual facility cost incurred shall result in disallowance of said cost unless failure to provide the information was caused by reasons beyond the control of the providers.

(m) For providers whose annual reimbursement from the Medicaid program exceeds one million dollars ($1,000,000), all contracts with related parties as defined in the Medicare Principles of Reimbursement as reflected in the HCFA-15, in the amount of ten thousands dollars($10,000) or more shall receive prior approval from the Division of Medical Assistance.

(1) Failure to file said contracts with the Division of Medical Assistance shall result in disallowance of the related cost from Medicaid reimbursement, unless failure to file said contracts was caused by reasons beyond the control of the provider.

(2) The contracts shall be filed with the Division of Medical Assistance ninety (90) days prior to the effective date of said contracts.

(n) "Donations," for purposes of this Section, shall mean grants, gifts, or income from endowments, cash or otherwise, given to a provider by a donor. "Unrestricted donations" shall mean donations given without restrictions by the donor as to their use. "Restricted donations" shall mean donations which the donor has specified the provider must use only for a specific purpose or within a specific time period designated by the donor, and shall not mean donations which the provider has restricted or designated for use for a specific purpose or within a specific time period.

(1) Providers are encouraged to raise donations to support their operations. Absent evidence to the contrary, donations shall be presumed used to support Medicaid program costs.

(2) Restricted donations for which the donor has specified a time period for the use of the donation shall be deemed to have been applied to support the provider's costs within the donor-specified time period.

(3) Unrestricted donations or restricted donations without a donor-specified time period for use shall be presumed to have been applied to support the provider's costs in the year in which such donations were acquired, unless the provider demonstrates otherwise by, without

limitation, the following factors:

(A) The documented decision of the Board of Directors or management as to the time for use of the funds.

(B) The provider's supporting documentation, including general ledger accounting, regarding the time period in which the donations were used.

(4) In determining whether non-Medicaid program costs are supported by donations, the following factors, without limitation, shall be considered:

(A) The decision of the provider's Board of Directors or management regarding the use of unrestricted donations.

(B) The donor's specifications, in cases of restricted donations.

(C) The provider's supporting documentation, including general ledger accounting, regarding use of donations.

(5) Costs included in the provider's Medicaid cost report which are supported by donations shall be reduced by the net value of the donations.

(A) The "net value" of a donation shall mean the fair market value of the donation minus the provider's reasonable costs of acquiring the donation.

(B) Reasonable costs of acquiring donations are those costs incurred by an economic and efficient provider.

(C) The provider's general ledger and supporting documents shall support the provider's reported cost of acquiring donations.

(D) The net value of a provider's donations shall not be less than zero.

(o) When multiple facilities or operations are owned by a single entity with a central office, the central office records shall be maintained as a separate set of records with costs and revenues separately identified and appropriately allocated to individual facilities. Allocation of central office costs shall be reasonable and conform to the directives of the Division of Medical Assistance and generally accepted accounting principles. Such costs are allowable only to the extent that the central office is providing services related to client care and the provider can demonstrate that the central office costs improved efficiency, economy, or quality of recipient care. The burden of demonstrating that costs are client related lies with the provider.

(1) If a provider has business enterprises other than those reimbursed by Medicaid, then the revenues, expenses, statistical and financial records for such enterprises shall be clearly identifiable from the records of the operations reimbursed by Medicaid.

(2) If an audit establishes that records are not maintained so as to clearly identify Medicaid information, none of the co-mingled costs shall be recognized as Medicaid allowable costs and the provider's rate shall be adjusted to reflect the disallowance as of the earlier of the commencement of the rate period related to the co-mingled costs, or the commencement of the co-mingling of said costs.

(3) After the co-mingled costs have been satisfactorily allocated and reported to the Division of Medical Assistance, and based on a showing by the provider that procedures have been implemented to insure that the co-mingling will not occur in the future, the Division of Medical Assistance shall retroactively adjust the facility's rate.

(4) Central office costs are generally charged to the Administrative and General cost center. In some cases, however, personnel costs which are direct patient care oriented may be allocated to direct care cost centers if time records are maintained to document the performance of direct patient care services. No home office overhead may be so allocated. The basis of this allocation among facilities participating in the North Carolina Medicaid program may be:

(A) specific time records of work performed at each facility,

(B) client days in each facility to which the costs apply relative to the total client days in all the facilities to which the costs apply, or

(C) any other allocation method approved by the Division of Medical Assistance, based on the HCFA-15, generally accepted accounting principles, and the preponderance of evidence of a case-by-case review.

(p) All criteria and limitations used by the Division of Medical Assistance to subject individual provider cost data to tests of reasonableness shall be based on the HCFA-15, generally accepted accounting principles, and the preponderance of evidence derived from an in-depth case by case review of all related facts and circumstances. In determining reasonableness of costs, the Division of Medical Assistance may compare major cost centers or total costs of similar providers and may request satisfactory documentation from providers whose cost do not appear to be reasonable. Similar providers are those with like levels of client care, size, and geographic location.

(q) Start-up costs are costs incurred by an ICF-MR facility while preparing to provide services at said facility. They include the cost incurred by providers to provide services at the level necessary to obtain certification less any revenue or grants related to start-up. The North Carolina Medicaid Program shall reimburse these start-up costs up to a maximum equal to the facility's **initial** rate, **determined under Section .0304 (m),** times **certified** beds times 120 days.

(1) Effective for all facilities whose Certificate of Need was granted on or after January 1, **1993, start-up costs** shall be amortized over a thirty-six (36) month period and shall be reported as administrative and general in the cost report. No advance of these start-up costs shall be made. These costs shall not be included in calculating the facility's total AG/OMP costs for rate setting purposes in accordance with this Plan. **These costs**

shall be paid manually outside of the per diem rate, with equalized payments made each month over the 36 month amortization period.

(2) Effective for all facilities whose CON was granted prior to January 1, 1993, the start-up reimbursement shall be made in addition to the facility's per diem rate. No advance of start-up funds shall be made prior to the submission of the start-up cost report. An interim payment not to exceed eighty percent (80%) of the allowable start-up costs can be made at the written request of a provider after a start-up cost report has been filed. The remaining balance of appropriately incurred start-up costs shall be paid after the desk audit of the start-up cost report has been completed. **These start-up cost payments are made manually outside of the per diem rate.** Any balance due to the Medicaid program shall be repaid promptly.

(3) A start-up cost report shall be filed with the Division of Medical Assistance. A copy of the start-up cost report shall be provided by the Division of Medical Assistance to each newly Medicaid certified facility.

(A) A start up cost report shall be filed with the Division of Medical Assistance Audit Section.

(B) Schedule E of the start up cost report shall be filed with the Division of Medical Assistance's Rate Setting Section.

(4) Allowable start-up costs may include, but not be limited to:

(A) personal services expenses,

(B) utility expenses,

(C) property taxes,

(D) insurance expenses,

(E) employee training expenses,

(F) housekeeping expenses,

(G) repair and maintenance expenses,

(H) administrative expenses.

(5) All costs that are properly identifiable as organization costs shall be classified as such and excluded from start-up costs.

(6) Costs related to increasing bed capacity in an existing facility shall not be treated as start-up costs.

(r) Only that portion of management fees that is directly related to client care and is not otherwise functionally covered by the current staffing pattern is allowable in the calculation of a facility's actual, allowable, and reasonable costs. Management fees on a per diem basis shall be limited to seven (7) percent of the maximum intermediate care rate for nursing facilities enrolled in the Medicaid Program. Management fees shall be charged to the Administrative and General Cost Center. A portion of a management fee may be allocated to a direct patient care cost center if time records are maintained to document the performance of direct care services.. The amount so allocated may be equal only to the salary and fringe benefits of persons who are performing direct patient care services while

employed by the management company. Records to support these costs shall be made available to staff of the Division of Medical Assistance. The basis of this allocation among facilities participating in the North Carolina Medicaid program may be:

(1) specific time records of work performed at each facility, or
(2) client days in each facility to which the costs apply relative to the total client days in all facilities to which the cost apply.

(r) The following costs are considered non-allowable facility costs because they are not related to client care or are specifically disallowed under the North Carolina State Plan:

(1) bad depts;
(2) advertising, except personnel want ads, and one line yellow page (indicating facility address);
(3) charity, courtesy allowances, discounts, refunds, rebates and other similar items granted by the provider;
(4) life insurance (except for employee group plans and reasonable key man life insurance premiums required by financial institutions in an outstanding loan agreement);
(5) prescription drugs and insulin (available to recipients under the State Medicaid Drug Program);
(6) vending machine expenses;
(7) state or federal corporate income taxes, plus any penalties and interest;
(8) telephone, television, or radio for personal use of client;
(9) retainers, unless itemized services of equal value have been rendered;
(10) fines or penalties;
(11) ancillary costs that are billable to Medicare or other third party payers;
(12) property taxes and other expenses related to real estate deemed by the Division of Medical Assistance to be in excess of the reasonable amount needed for the physical facility;
(13) property taxes, insurance, maintenance and other expenses related to facility costs deemed by the Division of Medical Assistance to be in excess of the reasonable amount necessary for quality client care;
(14) costs associated with lawsuits filed against the Department of Health and Human Services which are not upheld by the courts;
(15) personal use of company assets resulting in unreasonable levels of compensation;
(16) meals provided to employees not involved in the modeling process required to meet the clients' habilitation plan;
(17) charitable contributions;
(18) costs, related to excessive or unnecessary levels of care;
(19) interest associated with Medicaid overpayment repayment plans agreed to by both the provider and the Division of Medical Assistance;
(20) costs related to frivolous appeals;
(21) costs resulting from provider negligence;

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(22) costs related to any illegal activity;

(23) costs disallowed on the associated tax return by the Internal Revenue Service, or the North Carolina Department of Revenue unless specifically allowable under this plan;

(24) promotional items designed to promote the provider's public image;

(25) costs associated with the interests of provider shareholders and not direct care related;

(26) costs related to client care incurred in prior years, unless specific approval acquired from the Division of Medical Assistance; Approval of said costs shall be based on the HCFA-15, generally accepted accounting principles, and the preponderance of evidence on a case-by-case-review;

(27) country club dues.

(t) Providers shall use a competitive bidding process in order to purchase or lease vehicles.

(1) Providers shall explore cost differentials between leasing and purchasing of vehicles and shall choose the least expensive alternative.

(2) Daily logs detailing the use of vehicles shall be maintained by the provider.

(u) Purchase of services, major renovations, capital equipment, and supplies that exceed five thousand dollars ($5,000) annually per facility shall be reasonably made consistent with the prudent buyer provisions of the HCFA-15.

(v) Reasonable costs associated with self-insurance programs are allowable, as determined by the Division of Medical Assistance. All material facts related to said programs shall be disclosed to the Division of Medical Assistance. Failure to disclose shall result in the disallowance of said costs, unless failure to disclose the information was caused by reasons beyond the control of the provider.

PAYMENT ASSURANCE

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.0306 PAYMENT ASSURANCES

(a) The State shall pay each provider of ICF-MR services in accordance with the requirements of the State plan and the Participation agreement, the amount determined under the plan.

(b) In no case shall the payment rate for services provided under the plan exceed the facility's customary charges to the general public for such services.

(c) The payment methods and standards set forth herein are designed to enlist the participation of any provider who operates a facility both economically and efficiently. Participation in the program shall be limited to providers of service who accept, as payment in full, the amounts paid in accordance with the State Plan. This reimbursement plan is effective consistent with and on approval of the State Plan for Medical Assistance.

(d) In all circumstances involving third party payment, Medicaid is the payor or last resort.

(e) The State may withhold payments to providers under the following circumstances:

(1) If the State has an expectation that the provider will not expend the total prospective rate for reasonable and allowable patient care costs, the State may, at its discretion, withhold a portion of each payment so as to avoid a large amount due back to the State.

(2) Upon provider termination from the Medicaid Program the State may withhold a sum of reimbursement settlements for all previous periods, including the period in which the termination occurred, are completed.

(3) Upon determination of any sum due the Medicaid Program or upon instruction from a legally authorized agent of State or Federal Government, the State may withhold sums to meet the obligations identified.

(4) Upon written request of the provider, and with good cause shown, the Division of Medical Assistance may approve a repayment schedule in lieu of withholding funds.

(5) The State may withhold up to twenty (20) percent per month of a provider's payment for failure to file a timely cost report or other relevant information related to a facility's operation and requested by the Division of Medical Assistance. These funds shall be released to the provider after the cost report or the related information requested by the Division of Medical Assistance is acceptably filed. The provider shall experience delayed payment while the check is routed to the State and split for the amount withheld.